2026 SESSION

ENROLLED

VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 38.2-3431 of the Code of Virginia, relating to benefits consortium; sponsoring association.

[H 353]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3431 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-3431. Application of article; definitions.

A. This article applies to group health plans and to health insurance issuers offering group health insurance coverage, and individual policies offered to employees of small employers.

Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization or multiple employer welfare arrangement providing health care plans for health care services that offers individual or group coverage to the small employer market in the Commonwealth shall be subject to the provisions of this article. Any issuer of individual coverage to employees of a small employer shall be subject to the provisions of this article if any of the following conditions are met:

1. Any portion of the premiums or benefits is paid by or on behalf of the employer;

2. The eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium;

3. The employer has permitted payroll deduction for the covered individual and any portion of the premium is paid by the employer, provided that the health insurance issuer providing individual coverage under such circumstances shall be registered as a health insurance issuer in the small group market under this article, and shall have offered small employer group insurance to the employer in the manner required under this article; or

4. The health benefit plan is treated by the employer or any of the covered individuals as part of a plan or program for the purpose of § 106, 125, or 162 of the United States Internal Revenue Code.

B. For the purposes of this article:

"Actuarial certification" means a written statement by a member of the American Academy of Actuaries or other individual acceptable to the Commission that a health insurance issuer is in compliance with the provisions of this article based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the health insurance issuer in establishing premium rates for applicable insurance coverage.

"Affiliation period" means a period which, under the terms of the health insurance coverage offered by a health maintenance organization, must expire before the health insurance coverage becomes effective. The health maintenance organization is not required to provide health care services or benefits during such period and no premium shall be charged to the participant or beneficiary for any coverage during the period.

1. Such period shall begin on the enrollment date.

2. An affiliation period under a plan shall run concurrently with any waiting period under the plan.

"Beneficiary" has the meaning given such term under section 3(8) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (8)).

"Bona fide association" means, with respect to health insurance coverage offered in the Commonwealth, an association which:

1. Has been actively in existence for at least five years;

2. Has been formed and maintained in good faith for purposes other than obtaining insurance;

3. Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of an employee);

4. Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to such members (or individuals eligible for coverage through a member);

5. Does not make health insurance coverage offered through the association available other than in connection with a member of the association; and

6. Meets such additional requirements as may be imposed under the laws of the Commonwealth.

"Certification" means a written certification of the period of creditable coverage of an individual under a group health plan and coverage provided by a health insurance issuer offering group health insurance coverage and the coverage if any under such COBRA continuation provision, and the waiting period if any

ENROLLED

HB353ER

57 and affiliation period if applicable imposed with respect to the individual for any coverage under such plan.
58 "Church plan" has the meaning given such term under section 3(33) of the Employee Retirement Income
59 Security Act of 1974 (29 U.S.C. § 1002 (33)).
60 "COBRA continuation provision" means any of the following:
61 1. Section 4980B of the Internal Revenue Code of 1986 (26 U.S.C. § 4980B), other than subsection (f)(1)
62 of such section insofar as it relates to pediatric vaccines;
63 2. Part 6 of subtitle B of Title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. §
64 1161 et seq.), other than section 609 of such Act; or
65 3. Title XXII of P.L. 104-191.
66 "Creditable coverage" means with respect to an individual, coverage of the individual under any of the
67 following:
68 1. A group health plan;
69 2. Health insurance coverage;
70 3. Part A or B of Title XVIII of the Social Security Act (42 U.S.C. § 1395c or § 1395);
71 4. Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), other than coverage consisting solely of
72 benefits under section 1928;
73 5. Chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.);
74 6. A medical care program of the Indian Health Service or of a tribal organization;
75 7. A state health benefits risk pool;
76 8. A health plan offered under Chapter 89 of Title 5, United States Code (5 U.S.C. § 8901 et seq.);
77 9. A public health plan (as defined in federal regulations);
78 10. A health benefit plan under section 5 (e) of the Peace Corps Act (22 U.S.C. § 2504(e)); or
79 11. Individual health insurance coverage.
80 Such term does not include coverage consisting solely of coverage of excepted benefits.
81 "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the
82 policy, contract or plan covering the eligible employee.
83 "Eligible employee" means an employee who works for a small group employer on a full-time basis, has a
84 normal work week of 30 or more hours, has satisfied applicable waiting period requirements, and is not a
85 part-time, temporary or substitute employee. At the employer's sole discretion, the eligibility criterion may be
86 broadened to include part-time employees.
87 "Eligible individual" means such an individual in relation to the employer as shall be determined:
88 1. In accordance with the terms of such plan;
89 2. As provided by the health insurance issuer under rules of the health insurance issuer which are
90 uniformly applicable to employers in the group market; and
91 3. In accordance with all applicable law of the Commonwealth governing such issuer and such market.
92 "Employee" has the meaning given such term under section 3(6) of the Employee Retirement Income
93 Security Act of 1974 (29 U.S.C. § 1002 (6)).
94 "Employer" has the meaning given such term under section 3(5) of the Employee Retirement Income
95 Security Act of 1974 (29 U.S.C. § 1002 (5)), except that such term shall include only employers of two or
96 more employees.
97 "Enrollment date" means, with respect to an eligible individual covered under a group health plan or
98 health insurance coverage, the date of enrollment of the eligible individual in the plan or coverage or, if
99 earlier, the first day of the waiting period for such enrollment.
100 "Excepted benefits" means benefits under one or more (or any combination thereof) of the following:
101 1. Benefits not subject to requirements of this article:
102 a. Coverage only for accident, or disability income insurance, or any combination thereof;
103 b. Coverage issued as a supplement to liability insurance;
104 c. Liability insurance, including general liability insurance and automobile liability insurance;
105 d. Workers' compensation or similar insurance;
106 e. Medical expense and loss of income benefits;
107 f. Credit-only insurance;
108 g. Coverage for on-site medical clinics; and
109 h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are
110 secondary or incidental to other insurance benefits.
111 2. Benefits not subject to requirements of this article if offered separately:
112 a. Limited scope dental or vision benefits;
113 b. Benefits for long-term care, nursing home care, home health care, community-based care, or any
114 combination thereof; and
115 c. Such other similar, limited benefits as are specified in regulations.
116 3. Benefits not subject to requirements of this article if offered as independent, noncoordinated benefits:
117 a. Coverage only for a specified disease or illness; and
118 b. Hospital indemnity or other fixed indemnity insurance.

119 4. Benefits not subject to requirements of this article if offered as separate insurance policy:
120 a. Medicare supplemental health insurance (as defined under section 1882 (g)(1) of the Social Security
121 Act (42 U.S.C. § 1395ss (g)(1));
122 b. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (10
123 U.S.C. § 1071 et seq.); and
124 c. Similar supplemental coverage provided to coverage under a group health plan.
125 "Federal governmental plan" means a governmental plan established or maintained for its employees by
126 the government of the United States or by an agency or instrumentality of such government.
127 "Governmental plan" has the meaning given such term under section 3(32) of the Employee Retirement
128 Income Security Act of 1974 (29 U.S.C. § 1002 (32)) and any federal governmental plan.
129 "Group health insurance coverage" means in connection with a group health plan, health insurance
130 coverage offered in connection with such plan.
131 "Group health plan" means an employee welfare benefit plan (as defined in section 3 (1) of the Employee
132 Retirement Income Security Act of 1974 (29 U.S.C. § 1002 (1)), to the extent that the plan provides medical
133 care and including items and services paid for as medical care to employees or their dependents (as defined
134 under the terms of the plan) directly or through insurance, reimbursement, or otherwise.
135 "Health benefit plan" means any accident and health insurance policy or certificate, health services plan
136 contract, health maintenance organization subscriber contract, plan provided by a MEWA or plan provided
137 by another benefit arrangement. "Health benefit plan" does not mean accident only, credit, or disability
138 insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the
139 United States government; Medicare supplement or long-term care insurance; Medicaid coverage; dental only
140 or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited
141 benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a
142 workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of
143 income benefits; or insurance under which benefits are payable with or without regard to fault and that is
144 statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
145 "Health insurance coverage" means benefits consisting of medical care (provided directly, through
146 insurance or reimbursement, or otherwise and including items and services paid for as medical care) under
147 any hospital or medical service policy or certificate, hospital or medical service plan contract, or health
148 maintenance organization contract offered by a health insurance issuer.
149 "Health insurance issuer" means an insurance company, or insurance organization (including a health
150 maintenance organization) which is licensed to engage in the business of insurance in the Commonwealth and
151 which is subject to the laws of the Commonwealth which regulate insurance within the meaning of section
152 514 (b)(2) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1144 (b)(2)). Such term
153 does not include a group health plan.
154 "Health maintenance organization" means:
155 1. A federally qualified health maintenance organization;
156 2. An organization recognized under the laws of the Commonwealth as a health maintenance
157 organization; or
158 3. A similar organization regulated under the laws of the Commonwealth for solvency in the same manner
159 and to the same extent as such a health maintenance organization.
160 "Health status-related factor" means the following in relation to the individual or a dependent eligible for
161 coverage under a group health plan or health insurance coverage offered by a health insurance issuer:
162 1. Health status;
163 2. Medical condition (including both physical and mental illnesses);
164 3. Claims experience;
165 4. Receipt of health care;
166 5. Medical history;
167 6. Genetic information;
168 7. Evidence of insurability (including conditions arising out of acts of domestic violence); or
169 8. Disability.
170 "Individual health insurance coverage" means health insurance coverage offered to individuals in the
171 individual market, but does not include coverage defined as excepted benefits. Individual health insurance
172 coverage does not include short-term limited duration coverage.
173 "Individual market" means the market for health insurance coverage offered to individuals other than in
174 connection with a group health plan.
175 "Large employer" means, in connection with a group health plan or health insurance coverage with
176 respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on
177 business days during the preceding calendar year and who employs at least one employee on the first day of
178 the plan year.
179 "Large group market" means the health insurance market under which individuals obtain health insurance

180 coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a
181 group health plan maintained by a large employer.
182 "Late enrollee" means, with respect to coverage under a group health plan or health insurance coverage
183 provided by a health insurance issuer, a participant or beneficiary who enrolls under the plan other than
184 during:
185 1. The first period in which the individual is eligible to enroll under the plan; or
186 2. A special enrollment period as required pursuant to subsections J through M of § 38.2-3432.3.
187 "Medical care" means amounts paid for:
188 1. The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of
189 affecting any structure or function of the body;
190 2. Transportation primarily for and essential to medical care referred to in subdivision 1; and
191 3. Insurance covering medical care referred to in subdivisions 1 and 2.
192 "Network plan" means health insurance coverage of a health insurance issuer under which the financing
193 and delivery of medical care (including items and services paid for as medical care) are provided, in whole or
194 in part, through a defined set of providers under contract with the health insurance issuer.
195 "Nonfederal governmental plan" means a governmental plan that is not a federal governmental plan.
196 "Participant" has the meaning given such term under section 3(7) of the Employee Retirement Income
197 Security Act of 1974 (29 U.S.C. § 1002 (7)).
198 "Placed for adoption," or "placement" or "being placed" for adoption, in connection with any placement
199 for adoption of a child with any person, means the assumption and retention by such person of a legal
200 obligation for total or partial support of such child in anticipation of adoption of such child. The child's
201 placement with such person terminates upon the termination of such legal obligation.
202 "Plan sponsor" has the meaning given such term under section 3(16)(B) of the Employee Retirement
203 Income Security Act of 1974 (29 U.S.C. § 1002 (16)(B)).
204 "Preexisting condition exclusion" means, with respect to coverage, a limitation or exclusion of benefits
205 relating to a condition based on the fact that the condition was present before the date of enrollment for such
206 coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received
207 before such date. Genetic information shall not be treated as a preexisting condition in the absence of a
208 diagnosis of the condition related to such information.
209 "Premium" means all moneys paid by an employer and eligible employees as a condition of coverage
210 from a health insurance issuer, including fees and other contributions associated with the health benefit plan.
211 "Rating period" means the 12-month period for which premium rates are determined by a health insurance
212 issuer and are assumed to be in effect.
213 "Self-employed individual" means an individual who derives a substantial portion of his income from a
214 trade or business (i) operated by the individual as a sole proprietor, (ii) through which the individual has
215 attempted to earn taxable income, and (iii) for which he has filed the appropriate Internal Revenue Service
216 Form 1040, Schedule C or F, for the previous taxable year.
217 "Service area" means a broad geographic area of the Commonwealth in which a health insurance issuer
218 sells or has sold insurance policies on or before January 1994, or upon its subsequent authorization to do
219 business in Virginia.
220 "Small employer" means in connection with a group health plan or health insurance coverage with respect
221 to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50
222 employees on business days during the preceding calendar year and who employs at least one employee on
223 the first day of the plan year. In determining whether a corporation or limited liability company employed an
224 average of at least one individual during the preceding calendar year and employed at least one employee on
225 the first day of the plan year, an individual who performed any service for remuneration under a contract of
226 hire, written or oral, express or implied, for a (i) corporation of which the individual is a shareholder or an
227 immediate family member of a shareholder or (ii) a limited liability company of which the individual is a
228 member shall be deemed to be an employee of the corporation or the limited liability company, respectively.
229 However, a health insurance issuer shall not be required to issue more than one group health plan for each
230 employer identification number issued by the Internal Revenue Service for a business entity, without regard
231 to the number of shareholders or members of such business entity. "Small employer" includes a self-
232 employed individual.
233 "Small group market" means the health insurance market under which individuals obtain health insurance
234 coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a
235 group health plan maintained by a small employer.
236 "Sponsoring association" means a nonstock corporation formed under the Virginia Nonstock Corporation
237 Act (§ 13.1-801 et seq.) that:
238 1. Has been formed and maintained in good faith for purposes other than obtaining or providing health
239 benefits;
240 2. Does not condition membership in the sponsoring association on any factor relating to the health status

241 of an individual, including an employee of an employer member of the sponsoring association or a dependent
242 of such an employee;
243 3. Makes any health benefit plan available to all members regardless of any factor relating to the health
244 status of such members or individuals eligible for coverage through another member;
245 4. Does not make any health benefit plan available to any person who is not a member of the association;
246 5. Makes available health plans or health benefit plans that meet the requirements for health benefit plans
247 set forth in subdivision B 3 of § 38.2-3420;
248 6. Operates as a nonprofit entity under § *501(c)(3),* 501(c)(5)*,* or 501(c)(6) of the Internal Revenue Code;
249 7. Has been in active existence for at least five years; and
250 8. Meets such additional requirements as may be imposed under the laws of the Commonwealth.
251 "Sponsoring association" includes any wholly owned subsidiary of a sponsoring association.
252 "State" means each of the several states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam,
253 American Samoa, and the Northern Mariana Islands.
254 "Waiting period" means, with respect to a group health plan or health insurance coverage provided by a
255 health insurance issuer and an individual who is a potential participant or beneficiary in the plan, the period
256 that must pass with respect to the individual before the individual is eligible to be covered for benefits under
257 the terms of the plan. If an employee or dependent enrolls during a special enrollment period pursuant to
258 subsections J through M of § 38.2-3432.3 or as a late enrollee, any period before such enrollment is not a
259 waiting period.
260 C. The provisions of this section shall not apply in any instance in which the provisions of this section are
261 inconsistent or in conflict with a provision of Article 6 (§ 38.2-3438 et seq.) of Chapter 34.